Diagnosis and Treatment Plan



Patient Name: Date:

Treating Provider Name:

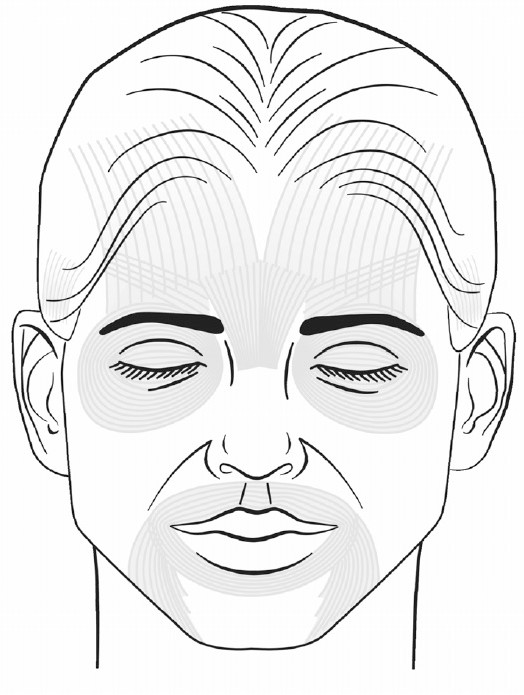
Health History Completed? Yes □ No □ Date: Provider Initial:

Dental / Head and Neck Examination Completed? Yes □ No □ Date: Provider Initial:

Informed Consent Completed? Yes □ No □



* M26.00 Anomalies of jaw size
* M26.12 Maxillary asymmetry
* K08.109 Loss of teeth
* M26.9 Dentofacial anomalies
* K13.0 Diseases of lips
* S01.551 Cheek/Lip biting
* K08.419 Loss of teeth trauma
* M26.12 Jaw asymmetry
* M26.50 Dentofacial abnormal funct
* Other
* Other
* Other



|  |  |  |
| --- | --- | --- |
| Areas Treated | Vials | Total Volume (mL) |
| **Kybella** |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

© American Academy of Facial Esthetics LLC, all rights reserved, no duplication allowed.